TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CONSULTANTS IN PAIN MEDICINE

MFDR Tracking Number
M4-17-0684-01

MFDR Date Received
November 18, 2016

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All the required information was submitted in a timely manner. We filed our corrected claim on June 13, 2016 after we received denial of 05/04/16. This is well within the 95 day time frame. We also have authorization to treat patient which is attached for review. Please review our claim and reprocess for payment."

Amount in Dispute: $217.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Claim [claim #] is a participant in the Texas Star Network... Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 4, 2016	99213	$217.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §134.600 sets out the preauthorization guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes.
   - CAC-18 — Exact duplicate claim/service
   - 224— Duplicate charge

Issues

1. Did the requestor meet the exception outlined in Chapter 1305.006?
2. Did the requestor submit a "correct" bill to the insurance carrier?
3. Is the requestor entitled to reimbursement for the disputed CPT Code 99213?

Findings

1. The insurance carrier denied/reduced the disputed services with reason code; "CAC-18 — Exact duplicate claim/service" and "224 – Duplicate charge."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Chapter 1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the documentation submitted by the requestor supports that the requestor obtained an out-of-network approval issued by Coventry Workers' Comp Services, dated April 14, 2015 and states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved... The extent of treatment to be provided as the approved out-of-network provider is limited to the referral consultation and/or services not available within the network."

   The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(3). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. The insurance carrier denied the disputed services with claim adjustment reason code "CAC-18 — Exact duplicate claim/service" and "224 – Duplicate charge."

   The respondent states, "In review of your explanation of benefits, it seems that you denied the claim as timely. We feel this was denied in error. All the required information was submitted in a timely manner. We filed our corrected claim on June 13, 2016 after we received denial of 05/04/16. This is well within the 95 day time frame. We also have authorization to treat patient which is attached for review. Please review our claim and reprocess for payment."

   The Division finds that the requestor initially billed CPT Code 99214 as indicated on the EOB with an audit date of May 4, 2016. The insurance carrier denied the disputed CPT Code with denial reason code "CAC-150 – Payer deems the information submitted does not support this level of service."

   The requestor asserts that a "corrected" bill was submitted to the insurance carrier on June 13, 2016, down coding the disputed code from 99214 to 99213. The requestor asserts that the insurance carrier denied the disputed CPT Code 99213 submitted on June 13, 2016 for timely filing, however failed to submit or include a copy of that EOB with the dispute request. The requestor submitted a copy of an EOB with an audit date of October 25, 2016 for CPT Code 99213, which contained the denial reason(s) noted above.

3. The Division finds the following:

   Pursuant to Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

   (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
(1) the date received, if sent by fax, personal delivery or electronic transmission or,
(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted documentation finds the following: The requestor submitted two copies of EOB's, the first EOB contains an audit date of May 4, 2016 and denied CPT Code 99214 with denial reason code "CAC-150 – Payer deems the information submitted does not support this level of service." The requestor submitted a "corrected bill" to the insurance carrier according to the requestor on June 13, 2016 after the receipt of the denial dated May 4, 2016. The second EOB audited CPT Code 99213 and contains an audit date of October 25, 2016 and was denied by the insurance carrier with denial reasons codes "CAC-18 — Exact duplicate claim/service" and "224 – Duplicate charge."

The Division finds that the requestor submitted insufficient documentation to support that a "corrected" bill was submitted to the insurance carrier within 95 days as required by 28 Texas Administrative Code §133.20(b). As a result, the requestor is not entitled to reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 2, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.